Maine

CHILD WELFARE SERVICES OMBUDSMAN

16TH ANNUAL REPORT • 2018

CHILDREN'S OMBUDSMAN

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The 2018 Maine Child Welfare Ombudsman Annual Report was written and prepared by:

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I am honored to present the sixteenth annual report of the Maine Child Welfare Ombudsman. Maine Child Welfare Ombudsman, Inc. is an independent non-profit solely dedicated to fulfilling the duties and responsibilities promulgated in 22 M.R.S.A. § 4087-A. The Child Welfare Ombudsman provides neutral investigations of complaints brought forth against the Maine Department of Health and Human services, Office of Child and Family Services ("the Department"). The Ombudsman also provides information about child welfare services to the public.

This year was marked by the heartbreaking deaths of two young girls, Marissa Kennedy and Kendall Chick. These deaths brought into sharp focus the realities of the child welfare system, and highlighted difficulties and trends that have been at issue for many years. While the details of these deaths have not been made public, the resulting attention and reforms have been necessary for the safety and well-being of thousands of other anonymous children who are at risk of harm or who have been harmed by their parents or caregivers.

In August of this year, a package of reform bills was passed by the legislature and signed into law by Governor LePage in September, increasing staffing and adding other resources to help support front line staff and foster parents. These newly enacted laws were a substantial step in the right direction, but further reforms are necessary:

- Caseworkers and supervisors must receive rigorous and ongoing training in investigative techniques so that the two most important decisions in the life of a case can be made correctly: 1) whether the home is unsafe and 2) whether a child should be safely returned to a parent. All other considerations are secondary in importance to this. Staffing must be sufficient to give caseworkers and supervisors time to complete training, support new staff, and handle a reasonable caseload.
- The Office of Program Evaluation and Government Accountability ("OPEGA") is completing a survey of child welfare employees in the Department, as well as assessing the effectiveness of reforms implemented internally by the Department. OPEGA's forthcoming report, as well as the previous report issued after reviewing the deaths of Marissa Kennedy and Kendall Chick should be used by the Governor, Legislature and the Department to inform continued reforms that are effective and discontinue those that are not.
- The Child Welfare Ombudsman has a unique vantage point from which to view the child welfare system throughout the state. The considerable knowledge gained from reviewing hundreds of confidential case records is invaluable in identifying primary problems within the complex system of child welfare. The Ombudsman's office is a resource that has been underutilized by the Department and lawmakers, partly due to a lack of resources within the Ombudsman's office. Strengthening the ability of the Ombudsman to advocate for necessary case specific and systemic change would be a clear way to strengthen the system as a whole. Redefining the structure of the office, increasing staff to adequately respond to requests and improving visibility of the office are recommendations made by the Ombudsman Board of Directors.

In Maine there is now momentum to support much needed changes in Child Welfare. The urgency that exists now cannot be lost or the Department will not have the support and resources necessary to protect children in both the long and short term. I would like to thank both Governor LePage and the Maine Legislature for continuing to support the Maine Child Welfare Ombudsman and I look forward to working with the Governor, Legislature and the Department to continue to improve practice, policy and law in a joint effort to keep children safe.

Sincerely,

Christine Alberi, Child Welfare Services Ombudsman

WHAT IS *the Maine Child Welfare Services Ombudsman?*

The Maine Child Welfare Services Ombudsman Program is contracted directly with the Governor's Office and is overseen by the Department of Administrative and Financial Services.

The Ombudsman is authorized by 22 M.R.S.A. §4087-A to provide information and referrals to individuals requesting assistance and to set priorities for opening cases for review when an individual calls with a complaint regarding child welfare services in the Maine Department of Health and Human Services.

MERRIAM-WEBSTER ONLINE defines an *Ombudsman* as:

1: a government official (as in Sweden or New Zealand) appointed to receive and investigate complaints made by individuals against abuses or capricious acts of public officials

2: someone who investigates reported complaints (as from students or consumers), reports findings, and helps to achieve equitable settlements

The Ombudsman will consider the following factors when determining whether or not to open a case for review:

1. The degree of harm alleged to the child.
2. If the redress requested is specifically prohibited by court order.
3. The demeanor and credibility of the caller.
4. Whether or not the caller has previously contacted the program administrator, senior management, or the governor's office.
5. Whether the policy or procedure not followed has shown itself previously as a pattern of non-compliance in one district or throughout DHHS.
6. Whether the case is already under administrative appeal.
7. Other options for resolution are available to the complainant.
8. The complexity of the issue at hand.

An investigation may not be opened when, in the judgment of the Ombudsman:

1. The primary problem is a custody dispute between parents.
2. The caller is seeking redress for grievances that will not benefit the subject child.
3. There is no specific child involved.
4. The complaint lacks merit.

The office of the Child Welfare Ombudsman exists to help improve child welfare practices both through review of individual cases and by providing information on rights and responsibilities of families, service providers and other participants in the child welfare system.

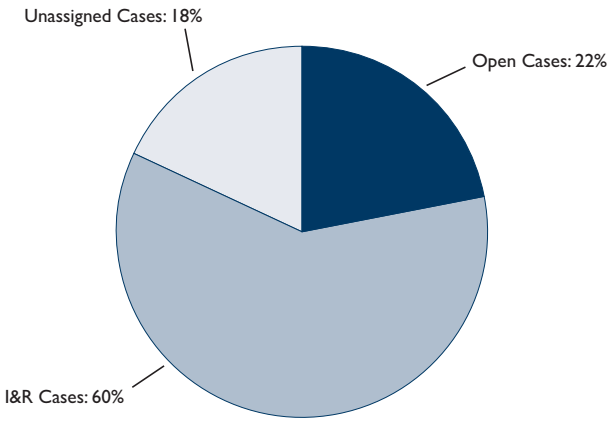
More information about the Ombudsman Program may be found at http://www.cwombudsman.org

DATA
from the Child Welfare Services Ombudsman

The data in this section of the annual report are from the Child Welfare Services Ombudsman database for the reporting period of October 1, 2017, through September 30, 2018.

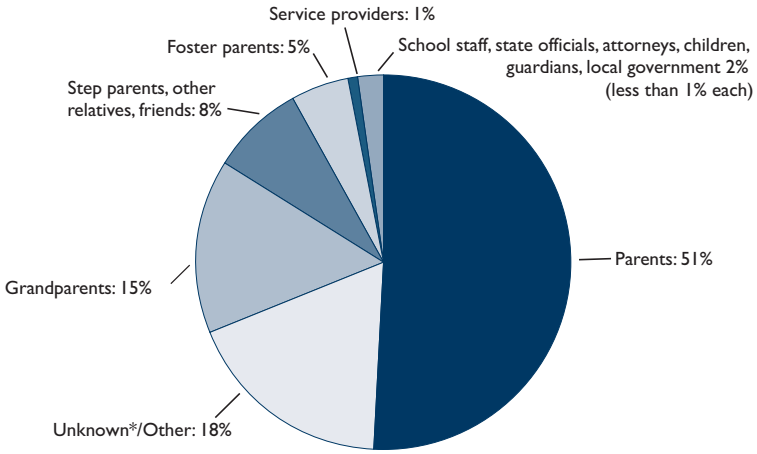
In Fiscal Year 2018, 605 inquiries were made to the Ombudsman Program, an increase of 101 inquiries from the previous fiscal year. As a result of these inquiries, 110 cases were opened for review (22%), 364 cases were given information or referred for services elsewhere (60%), and 131 cases were unassigned (18%). An unassigned case is the result of an individual who initiated contact with the Ombudsman Program, but who then did not complete the intake process. Our scheduling protocols allow each caller an opportunity to set up a telephone intake appointment.

HOW DOES THE OMBUDSMAN PROGRAM CATEGORIZE CASES?



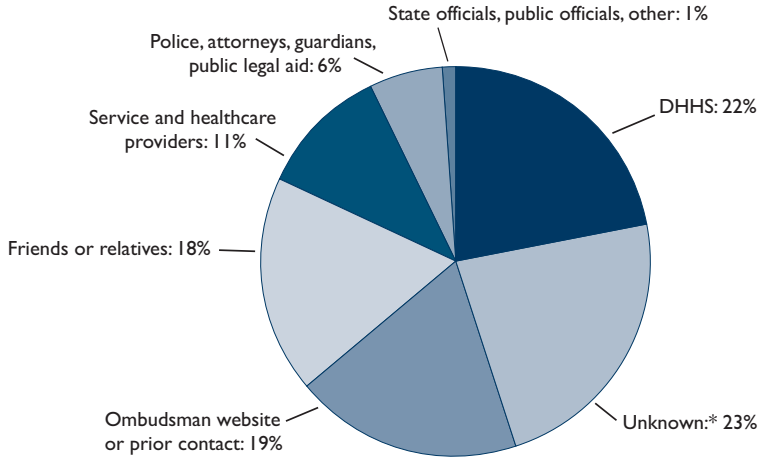
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2018, the highest number of contacts were from parents, followed by grandparents, then other relatives/friends, and foster parents.



HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

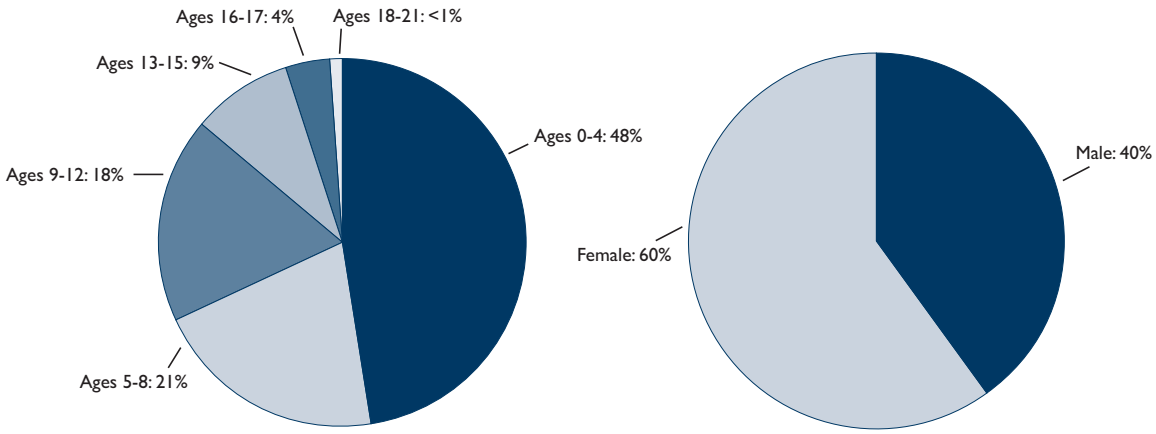
In 2018, nineteen percent of contacts learned about the program through the Ombudsman website or prior contact with the office. Twenty-two percent of contacts learned about the Ombudsman Program through the Department of Health and Human Services.



* *Unknown* represents those individuals who initiated contact with the Ombudsman, but who then did not complete the intake process for receiving services, or who were unsure where they obtained the telephone number.

WHAT ARE THE AGES & GENDER OF CHILDREN INVOLVED IN OPEN CASES?

The Ombudsman Program collects demographic information on the children involved in cases opened for review. There were 186 children represented in the 110 cases opened for review: 40 percent were male and 60 percent were female. During the reporting period, 69 percent of these children were age 8 and under.



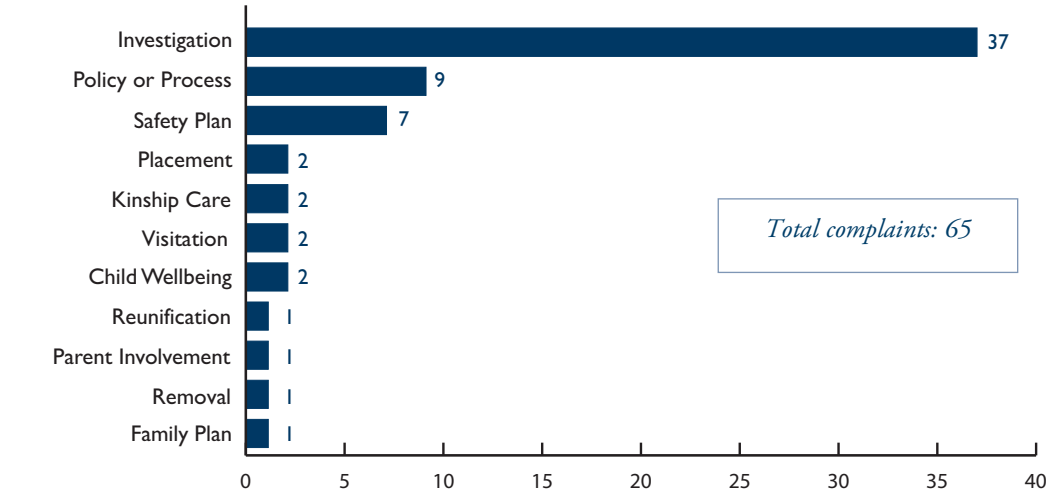
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT	CHILDREN	
DISTRICT #	OFFICE	CASES	% OF TOTAL	NUMBER	% OF TOTAL
0	Intake	2	2%	4	2%
1	Biddeford	18	16%	29	16%
2	Portland	9	8%	17	9%
3	Lewiston	13	12%	25	13%
4	Rockland	8	7%	8	4%
5	Augusta	27	25%	49	26%
6	Bangor	17	15%	29	16%
7	Ellsworth	12	11%	18	10%
8	Houlton	4	4%	7	4%
TOTAL		**110**	**100%**	**186**	**100%**

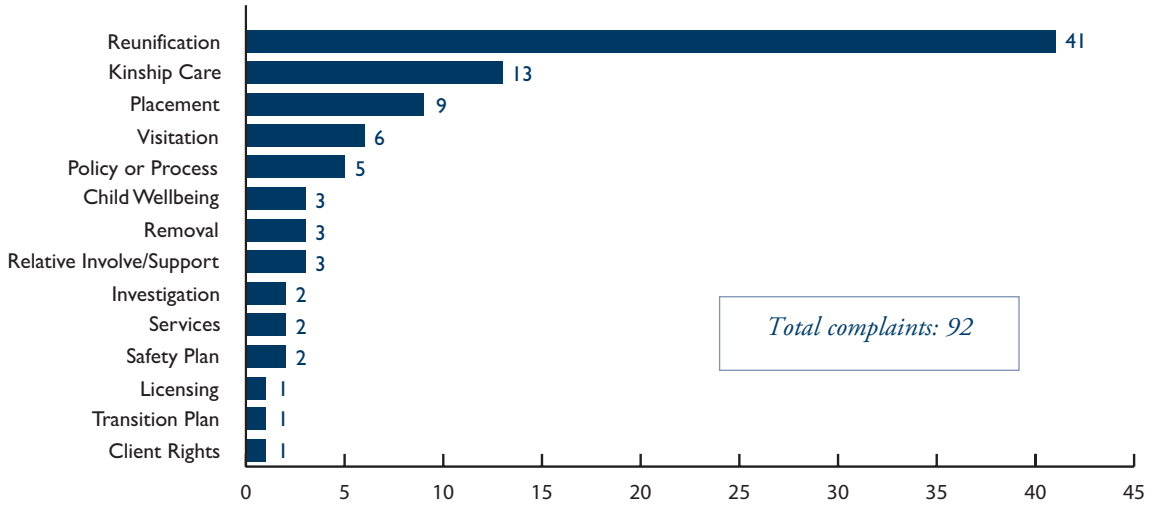
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 110 cases were opened with a total of 158 complaints. Each case typically involved more than one complaint. There were 65 complaints regarding Child Protective Services Units or Intakes, 92 complaints regarding Children's Services Units, most during the reunification phase.

Area of Complaint: **CHILD PROTECTIVE SERVICES (INITIAL ASSESSMENTS)**



Area of Complaint: **CHILDREN'S SERVICES UNITS (REUNIFICATION)**



HOW MANY CASES WERE CLOSED & HOW WERE THEY RESOLVED?

During the reporting period, the Ombudsman Program closed 108 cases that had been opened for review. These cases included 163 complaints and those are summarized in the table below.

VALID/RESOLVED complaints are those complaints that the Ombudsman has determined have merit, and changes have been or are being made by the Department in the best interests of the child or children involved.

VALID/NOT RESOLVED complaints are those complaints that the Ombudsman has determined have merit, but they have not been resolved for the following reasons:

1. ACTION CANNOT BE UNDONE: The issue could not be resolved because it involved an event that had already occurred.

2. DEPARTMENT DISAGREES WITH OMBUDSMAN: The Department disagreed with the Ombudsman's recommendations and would not make changes.

3. CHANGE NOT IN THE CHILD'S BEST INTEREST: Making a change to correct a policy or practice violation is not in the child's best interest.

4. LACK OF RESOURCES: The Department agreed with the Ombudsman's recommendations but could not make a change because no resource was available.

NOT VALID complaints are those that the Ombudsman has reviewed and has determined that the Department was or is following policies and procedures in the best interests of the child or children.

RESOLUTION	CHILD PROTECTIVE SERVICES UNITS	CHILDREN'S SERVICES UNITS	TOTAL
Valid/Resolved	1	6	7
Valid/Not Resolved*	14	13	27
1. Action cannot be undone	14	11	
2. Dept. disagrees with Ombudsman	0	0	
3. Lack of Resources	0	2	
Not Valid	57	76	133
TOTAL	**74**	**89**	**163**

* Total of numbers 1, 2, 3

During reviews of the 108 closed cases, the Ombudsman identified 26 additional complaint areas that were not identified by the original complainant. The 26 complaints were found to be valid in the following categories: 8 investigation, 6 reunification, 3 child-wellbeing, 2 services, 2 policy or process, 2 safety plan, 1 relative involvement,1 parent involvement, 1 removal.

POLICY AND PRACTICE
Findings and Recommendations

During the past fiscal year, the Ombudsman and the Department of Health and Human Services, Office of Child and Family Services ("the Department") have worked together in partnership on over one hundred individual cases. The Department has continued to sustain improved practice in the area of kinship placements and involvement of kin in child protective cases. The Department has continued to struggle in initial assessments of child safety. Case specific reviews in 2018 have also shown a heightened number of issues with reunification practice.

This has been a difficult and tragic year, marred by the deaths of Kendall Chick and Marissa Kennedy. Many changes in the practice of child welfare have occurred, but more work is needed.

- Caseworkers and supervisors must have increased and consistent training in investigative techniques to improve the assessment of child safety and ongoing assessment of the progress of parents working towards reunification with their children. As detailed below, these two practice areas continue to be a concern in the Department's caseworker practice.
- Caseworkers and supervisors must have sufficient resources, time, and support to complete ongoing training and manage a reasonable number of cases, including additional staff as necessary.
- The Office of Program Evaluation and Government Accountability ("OPEGA") is working to evaluate internal reforms made by the Department and surveying Department front line staff in order to make more recommendations for reform. The recommendations from the forthcoming report should be taken into full consideration to inform and implement further changes as necessary.

The Ombudsman has reviewed the Department's involvement around the deaths of Marissa Kennedy and Kendall Chick, but these cases are not specifically referenced in the sections below due to existing confidentiality law.

1. REUNIFICATION

For the first time in Fiscal year 2018 the Ombudsman has seen significant issues with reunification practice. After a child enters state custody, the Department is required to provide a reunification plan and reunification services to parents and permanency to children. Reunification services for parents must be tailored to the circumstances of each case and could include scheduled supervised or unsupervised visits with children, mental health and substance abuse evaluations and services, domestic violence counseling, family team meetings, and transportation. The Department is financially responsible for required reunification services if parents do not have insurance or other resources.

The brief synopses of individual cases below give examples of a variety of practice issues that most often involve lack of ongoing assessment of a case. The decision that the Department must make towards the end of the reunification period, whether a child will be safe with his parent going forward, is often difficult due to the complexity of the issues. This decision is made particularly difficult when the impact of a parent's mental health diagnosis is not understood or the mental health issue is not treated using evidence based therapy. If the correct services are not initiated or the parents' progress in services is not adequately assessed on an ongoing basis, this can result two undesirable outcomes: 1) children are reunified with parents when

the situation is not safe, or 2) there are unnecessary delays in reunification when children could have been sent home to parents sooner.

There were changes in reunification practices implemented by the Department in the beginning of 2017 and it is not clear whether some of these observed issues are as a result of these changes or due to other factors.

Cases included:

- a child entered state custody due to inflicted physical abuse and trial placement was started despite the fact that both parents had multiple serious issues that had not been evaluated or addressed through services;
- during trial placement DHHS received clear evidence that the original danger to the children continued and closed the case despite this;
- a child was reunified with a parent and a case closed leaving a child unsafe and the parent subsequently left the state with the child during a new assessment;
- a non-evidence based decision to start a trial placement before the parent was a safe caregiver that showed a lack of understanding of the parents' mental health issues;
- an unnecessary delay in starting trial placement for a family causing the children had to be in state custody for too long;
- a trial placement failure after the ongoing assessment of the parent's progress in reunification was inadequate;
- a trial placement that occurred too quickly due to Department miscommunication;
- a parent's progress in reunification was not adequately assessed and then the trial placement was not sufficiently monitored;
- parents did not receive good faith reunification services including face to face visits, family team meetings, contact with providers and sufficient visits with the children;
- trial placement began without consulting the team and without considering the parent's lack of progress in mental health services;
- ongoing assessment of a case was not conducted, including contact with providers and regular contact with a parent which resulted in children moving back in with a parent without the Department's knowledge;
- there was little face to face or other contact with parents, providers were not contacted and the issue of domestic violence was not addressed;
- outside of family team meetings little contact occurred with parents or providers and ongoing assessment of the parents' progress was not done and evaluations were completed late or not at all when better ongoing assessment would have resulted in faster permanency for the infant;
- face to face visits with children were not completed for several months, the parents' providers were not contacted and no random drug or alcohol screens were completed.

Department's Response: In the last year, the Department has recognized the need for increased support and structure around decision-making in child welfare practice in all phases of a case, including reunification. As a result, the Department has embarked on a number of initiatives to improve the quality and consistency of decision-making with regard to child safety. The new initiatives currently in the process of implementation include:

- Collaboration with the National Council on Crime and Delinquency (NCCD) to implement tools that will guide and ensure consistency in decision making related to case planning, reunification services, and case closure. The use of these Structured Decision Making (SDM) tools will be fully implemented, with all staff trained, by April of 2019.
- The Department strongly supported the passage of LD 1923 in the most recent legislative session. One component of LD 1923 is the expansion of Clinical Consultation Services available to each district office. This clinical consultation is meant to assist district office staff in analyzing complex cases by utilizing experts with a clinical skillset—allowing the Department to better analyze case decisions. The clinical consultation will also include support and debriefings for staff engaged in casework involving child death and serious injury.
- LD 1923 also included funding for a Supervised Visitation pilot program. The goal of this pilot is to provide an evaluation component within parent/child visits to assist the Department in determining when/if a parent is growing in their ability to safely parent the child and whether the parent is able to meet the particular needs of his/her child; and to provide additional evidence and an expert opinion regarding the parent's ability to safely parent his/her child. The provider will be able to share this information with the caseworker and supervisor to help inform case decisions regarding expansion of visits, trial home placements, and termination of parental rights. It is also expected that the provider's staff will testify in court when necessary. The Department has researched promising practices in supervised visitation from across the country and is currently in the process of developing the structure of Maine's pilot so a contracted provider can be secured.
- Team Decision Making (TDM) has long been a component of child welfare practice in Maine. The Department has just completed the rollout of a renewed emphasis on the use of TDM meetings in which Program Administrators and Assistant Program Administrators meet with the caseworker and supervisor to review the case and make pivotal case decisions, including those regarding trial home placement, expansion of visits, and filing for termination of parental rights.
- The Department is currently implementing a statewide Quality Improvement (QI) unit with staff in each district office. The QI staff will provide real-time feedback to caseworkers and supervisors to ensure staff are adhering to policy and statute throughout the life of the case, and that safety and risk are being consistently evaluated to inform case decisions. QI staff will also review case plans to ensure that safety and risk concerns are addressed, appropriate reunification services targeted to the reason for child welfare involvement are identified and included in the plan, and that casework staff facilitate participation in these services.
- The Department is finalizing the implementation of a number of new internal tools to ensure consistent decision-making regarding child safety. These include the automated supervisory checklist, the new streamlined family plan, and the trial home placement checklist. Each of these tools serves to bring the focus back to the best interest of the child, while balancing the Department's obligation to make reasonable efforts to rehabilitate parents in order to reunify them with their children.
- The Department strongly supported LD 1922, which changed the language in Maine law regarding reunification. Current law requires the Department "give family rehabilitation and reunification

priority." When LD 1922 goes into effect in December of 2018, the law will require that the Department make reasonable efforts to rehabilitate and reunify families. The Department anticipates that this change in language, which aligns with the federal reunification requirement, will further prioritize the child's safety interest while respecting the right of parents to parent their child.

- The Department is currently in the early stages of the development of a new Comprehensive Child Welfare Information System (CCWIS). This system will replace the aging Maine Automated Child Welfare Information System, which serves as the electronic repository for all child welfare information. This new system will modernize the electronic system used in child welfare and the Department anticipates that this will allow for improvements in the child welfare system. Some of the anticipated improvements include efficiencies in data entry and management that will allow caseworkers to spend less time on documentation and more time engaging with families; increased capacity for monitoring of case progress, data collection, and other oversight activities; an increase in the amount of guidance provided to staff via the electronic system; and the implementation of policy and procedure guides for staff within the electronic system.
- The Department's child welfare system is currently engaged in a complete system evaluation which is being conducted by a contracted provider with expertise in the field, Public Consulting Group (PCG). The Department has tasked PCG with evaluating Maine law, rule, policy, and practice in all areas of child welfare; researching evidence-based and promising practice in all areas of child welfare from across the country; making recommendations for systemic improvements throughout child welfare to ensure child safety, as well as timely and appropriate reunification; the development of a procedure manual that will guide staff and ensure consistent practice and decision-making in all cases; the implementation of staff training to improve consistency in casework practice; and the evaluation of caseload standards within Maine's child welfare system.

The Department strongly believes that all of these new initiatives will function together to support child welfare staff in making timely and consistent decisions regarding child safety, reunification, visitation, etc. The Ombudsman has provided a number of concerning examples, many of which illustrate casework practice gaps that OCFS has also identified and is working to address through these initiatives. The combined impact of the above initiatives is not yet known, but the Department will continue to review individual cases, aggregated data, and other sources of information to analyze the effectiveness of these initiatives in improving child welfare practice in the areas identified by the Department and the Ombudsman. While it is the intention of the Department that these initiatives will address many of the issues identified by the Ombudsman, the Department also remains committed to working with the Ombudsman's office on any issues that may arise involving concerning practice decisions, and the development of solutions for systemic improvement that address any new or ongoing concerns.

2. ASSESSMENTS AND SAFETY PLANNING

Throughout 2018 the Department continued to struggle with assessments and safety planning in multiple instances. There were multiple cases where children were left unsafe with parents and caregivers after DHHS opened and closed an assessment without protecting children or continued involvement without adequate ongoing assessment of the children.

Safety planning continued to be at issue. When parents and the Department agreed to a safety plan because children are at risk in their parents' care, safety plans have often exceeded a planned amount of time and were not properly monitored. Unstructured and poorly monitored safety plans often left children without the benefit of legal protection from their parents and additional resources such as the courts, foster homes and Guardians *ad litem*.

The Department has had difficulty following policy in many areas of assessments, such as having regular face to face contact with children and completing enough assessment activities to ensure that the level of risk to a child is low before an investigation is closed or referred to an alternative response program.

DHHS has recently made many changes to practice in safety planning and has committed to more training in assessment practice due to recent the recent children's deaths. For the most part the above issues occurred before the changes took effect so the overall effect on the system has not yet been observed by reviews done by the Ombudsman's office.

Department's Response: For many years the Department has depended on the practice of "safety planning" to ensure child safety while minimizing the Department's intrusive presence in the lives of children and families. This practice was consistent with the Department's goal of ensuring child safety in a manner that caused minimum disruption to the child's life. In the past, safety planning most often involved a child residing with a family member, family friend, or other loving and supportive adult with whom the child had a preexisting relationship. Safety plans were developed and implemented without the Department taking custody of the child. However, the Department recently began to analyze the use of safety planning and identified several issues. These concerns involved the time children spent in the care of someone other than their parents before a formal reunification process (overseen by the courts) was undertaken; the lack of support for, and emphasis on, parental rehabilitation in situations in which the Department has not taken court action; and the lack of services and supports available to individuals who are providing care for children when the child's parents are unable to do so safely. The Department has since taken steps to improve practice in this area. Primary among these changes was a shift in policy that now requires that safety plans be developed in which the child remains in the home with his/her parents while supports are put in place to mitigate threats to the child's safety identified by the Department. As a result of this change, children, parents, and resource caregivers are no longer left without the legal protections and status afforded to them when the courts become involved in a case. This ensures that the children's needs are met in a timely manner, the resource caregivers can be appropriately compensated and supported, and the progress of parents in reunification can be monitored and evaluated.

In addition, in December of 2018, staff will begin using the SDM Safety and Risk Assessment tools to guide decisions regarding a child's ability to remain safely in their parent's care. As part of this process, the Department's policy regarding assessments has been reviewed, strengthened, and updated. It is now known as the Investigation policy and provides clear guidance to staff on decision making regarding the investigation of allegations of abuse and/or neglect, as well as the decisions that may result from information gained during the investigation.

3. LACK OF MENTAL AND BEHAVIORAL HEALTH RESOURCES FOR CHILDREN IN NEED OF SERVICES

Maine has not allocated sufficient resources to effectively treat and keep safe older youth with serious mental health and behavioral issues. For example, after being discharged from a mental health hospital, a

fifteen year old child was placed in a temporary step down placement with no treatment available, and later at a homeless shelter. Another child, also fifteen, was harmed by a wait for crisis beds, a delay in placement in appropriate residential facility, and placements at the Preble Street Teen Center and New Beginnings Homeless Shelter. Both of these children were in state custody at the time.

Additionally, children continue to be harmed by waitlists for in home counseling services. Maine would also benefit from children's therapists trained in evidence based practices. Children's therapists in some cases made recommendations that were not based on clinical findings or evidence based practice that resulted in delayed trial placement or to kept children from visiting with parents, when it was safe and appropriate.

Department's Response: DHHS recognizes the challenges related to serving children with significant mental and behavioral health needs. To improve services available to youth in Maine, the Department has developed a Psychiatric Residential Treatment Facility (PRTF) to increase the number of youth that can be served in Maine, instead of being placed out-of-state to receive this level of service. The Department is also engaged in ongoing efforts to develop treatment foster care resources, including the implementation of recent legislation that increased the rates of reimbursement to foster parents. Furthermore, the Department is currently engaged in a full evaluation of Maine's children's behavioral health system of care. The Department has contracted with PCG, an independent provider with expertise in this field. Through this evaluation, the Department is seeking to improve the array of behavioral health services available for children and families in the State of Maine. The evaluation will utilize stakeholder input, systems analysis, and research on successful children's behavioral health systems across the country, to develop recommendations for systemic improvement. This study will serve as the basis for the development of a statewide strategic vision that ties together all the future initiatives and projects undertaken by the Department to ensure these initiatives are improving the programs and services available to clients, while eliminating inefficiencies in the system, and improving the outcomes for children and families.

CONCLUSION

The Governor, Legislature, and the Department have recently taken important steps towards adding crucial resources to child welfare services and the Department is making practice changes that will help protect children who are at risk of child abuse and neglect. While these steps are important, more work and resources are needed, as well as ongoing evaluation of the effectiveness of changes and flexibility in identifying additional needs.

ACKNOWLEDGMENTS

As the sixteenth year of the Maine Child Welfare Ombudsman program comes to a close, we would like to acknowledge and thank the many people who have continued to assure the success of the mission of the Child Welfare Ombudsman: to support better outcomes for children and families served by the child welfare system. Unfortunately, space does not allow the listing of all individuals and their contributions.

The staff of public and private agencies that provide services to children and families involved in the child welfare system, for their efforts to implement new ideas and provide care and compassion to families at the frontline, where it matters most.

Senior management and staff in the Office of Child and Family Services, led by Acting Director Kirsten Capeless for their ongoing efforts to make the support of families as the center of child welfare practice, to keep children safe,and to support social workers who work directly with families.

The Program Administrators of the District Offices, as well as the supervisors and social workers, for their openness and willingness to collaborate with the Ombudsman to improve child welfare practice.

The Board of Directors of the Maine Child Welfare Services Ombudsman, Ally Keppel, Allie McCormack, Maureen Boston, Virginia Marriner, and Katherine Knox for their support and dedication to our agency.

Child welfare caseworkers perform difficult, sometimes dangerous, stressful, and heartbreaking work every day with the objective of keeping children safe. These professionals care deeply about the children and families that they work with and deserve our support and thanks now more than ever. However, child welfare caseworkers cannot do this alone. Schools, clinicians, case managers, attorneys, police, housing, doctors, nurses, Guardians *ad litem*, behavioral health providers, transportation providers, hospitals, drug treatment programs, mental health facilities, and any number of other professional and community organizations are essential parts of the system. Support for key organizations and individuals outside of the Office of Child and Family Services means support for child welfare social workers, which in turn means support for children. These stakeholders are crucial and also deserve our thanks.

CHILD WELFARE OMBUDSMAN

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